IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202130 JULY 27, 2021

IHCP to revise limit on reimbursement of injection services, mass reprocess or mass adjust claims

The Indiana Health Coverage Programs (IHCP) applied a limit in the claim-processing system on the reimbursement of fee-for-service (FFS) outpatient claims for injection administration procedure codes billed on the same day as certain treatment room revenue codes, as announced in *Banner Page* BR201938. The affected procedure codes and revenue codes are listed in *BR201938* (see the article, *IHCP to apply claim-processing limit on reimbursement of injection services*).

The IHCP is clarifying that this reimbursement limit will be "per provider" and "per date of service." This limit includes codes billed on the same or different claims, and by the same provider. Effective Aug. 27, 2021, outpatient claims and claim details that meet this criteria (limit) will deny with explanation of benefits (EOB) 6404 – *Treatment room services and Injection/administration service procedures are not allowed on the same date of service*. This limit will apply retroactively to outpatient claims for injection administrative services with DOS on or after **Oct. 31, 2019**.

The IHCP identified a claim-processing issue that affects outpatient claims for the procedure codes and revenue codes described above. Claims processed during the indicated time frame that may have denied for EOB 6404 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning Sept. 15, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

Note: For general information about billing and reimbursement of injection services, see the Claim Submission and Processing provider reference module at in.gov/medicaid/providers.

IHCP announces Sandata Knowledge Center and Ticket Portal

The *21st Century Cures Act* directs Medicaid programs to require personal care service and home health service providers to use an electronic visit verification (EVV) system to document services rendered. See *Indiana Health Coverage Programs (IHCP) Bulletin* BT201855 for more information. The implementation date for requiring the use of an EVV system for personal care services was delayed to Jan. 1, 2021. The implementation date for requiring the use of an EVV system for home health services remains Jan. 1, 2023.

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The IHCP's state-sponsored EVV solution (Sandata) has created a new Knowledge Center and Sandata Ticket Portal. The system is intended for use by state-sponsored EVV solution users as well as alternate EVV vendors.

The Knowledge Center will help users find information, including:

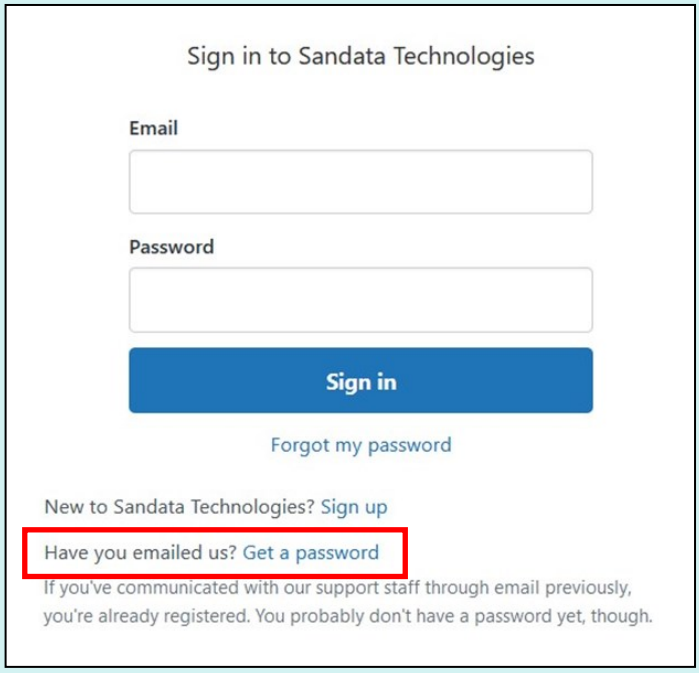
- Getting started tips
- Answers to commonly asked questions
- Links to state webpages
- Welcome Kit information
- Product user guides
- Training videos
- Release notes

The Sandata Ticket Portal will allow users to:

- Review all submitted tickets
- Update existing tickets
- Submit new ticket requests

The Knowledge Center and Sandata Ticket Portal are accessible from the Sandata website at sandata.zendesk.com. Providers who received welcome kits from Sandata are eligible to access the portal. When first visiting the portal, providers should click ***Please sign in to see more content*** in the banner at the top of the webpage, and then on ***Get a password*** (see Figure 1) to receive a temporary password.

Figure 1 – Get a password



IHCP modifies EVV to remove GPS Distance exception

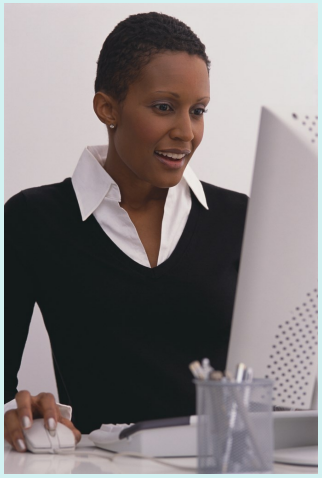
The *21st Century Cures Act* directs Medicaid programs to require personal care service and home health service providers to use an electronic visit verification (EVV) system to document services rendered. See *Indiana Health Coverage Programs (IHCP) Bulletin* BT201855 for additional information. The implementation date for requiring the use of an EVV system for personal care services was delayed to Jan. 1, 2021. The implementation date for requiring the use of an EVV system for home health services remains Jan. 1, 2023.

Effective for EVV records submitted on or after Aug. 6, 2021, the IHCP will remove the EVV record exception for *GPS Distance*. This change impacts both the Sandata state-sponsored EVV system as well as alternate or third-party EVV systems using mobile visit verification. This change means that EVV records will no longer need to be modified when the GPS location captured through mobile visit verification fails to match the location associated with the IHCP member. Providers are reminded that when using mobile visit verification, they are still required to capture the location through GPS.

For providers who use telephonic visit verification, Sandata will review all provider accounts to ensure that the EVV record exception *Unmatched Client ID and Phone* is correctly enabled.

Note: Sandata users can find information about EVV record exceptions in the Agency Provider Participant Guide, accessible through the Sandata portal on the Sandata website at sandata.zendesk.com.

Reminder for providers to avoid submitting duplicate claims



Following a recent review of fee-for-service (FFS) claims data, the Office of Medicaid Policy and Planning (OMPP), Program Integrity (PI) section, is reminding Indiana Health Coverage Programs (IHCP) providers to avoid submitting duplicate claims. A duplicate claim is any claim that is submitted two or more times by the same provider, for the same date of service (DOS), for the same member and for the same service or item. (This does not include corrected claims.) Duplicate claims are not reimbursed.

Duplicate claims increase administrative costs, time and resources for both the IHCP and the provider. If the provider exhibits a pattern of submitting duplicate claims, the provider may be required to undergo an audit or investigation.

Tips to avoid submitting duplicate claims

Consider doing the following before submitting a claim:

- Make any needed adjustments to the original claim instead of submitting a new claim.
- Determine whether a claim that denied should have included a modifier. To determine, review medical records and consult the claims and billing procedures provider reference modules, accessible from the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers.

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- Find the claim's status as described below. The status normally includes these details if applicable:
  - ⇒ Denied and why
  - ⇒ Suspended and why
  - ⇒ Rejected during pre-cycle edits and why

How to find a claim's status

Processed FFS claims and claim adjustments appear on the provider's monthly Remittance Advice (RA) or 835 electronic transaction. Providers (and their delegated representatives) can use the IHCP Provider Healthcare Portal (Portal) to check the status of a claim or claim adjustment.

For paper claims and claim adjustments submitted by mail, please allow at least 45 days before checking claim status on the Portal. Providers may call Provider Customer Assistance to inquire about status, but are encouraged to take advantage of the Portal. Refer to contact information in the *IHCP Quick Reference Guide* and to claims-related information on the *Contact Us* webpage at in.gov/medicaid/providers.

Note: For more information about submitting claims and the overall process, see the Claim Submission and Processing and Claim Adjustments provider reference modules at in.gov/medicaid/providers.

For claims submitted to a managed care entity (MCE), follow the MCE's procedures for checking status or making adjustments. MCE contact information is available on the *Contact Us* page at in.gov/medicaid/providers.

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